UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 03-10194-RWZ

UNITED STATES

v.

LAHEY CLINIC HOSPITAL

MEMORANDUM OF DECISION

April 30, 2004

ZOBEL, D.J.

Plaintiff United States, acting through the Department of Health and Human Services ("HHS"), administers and supervises the Health Insurance for the Aged and Disabled Program, under Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et seq., otherwise known as the Medicare Program ("Medicare"). During the relevant time period, the Health Care Financing Administration ("HCFA"), a component of HHS, was directly responsible for administering the Medicare Program. Defendant Lahey Clinic Hospital entered into a provider agreement with plaintiff, which allowed it to be reimbursed by Medicare through Blue Cross Blue Shield in Massachusetts. For reimbursement purposes, Medicare follows HCFA's three level Common Procedure Coding System ("HCPCS"). For Level One (the only level relevant here), HCPCS adopts the American Medical Association Physicians' Current Procedure Terminology (CPT) coding system in the CPT-4 Manual. Generally, costs for medical services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or

to improve the functioning of a malformed body member" are not reimbursable. 42 U.S.C. § 1395y(a)(1)(A); 42 C.F.R. § 411.15(k)(1).

Plaintiff contends that defendant billed it for one to three additional unnecessary hemogram indices (CPT-4 code 85029) every time it billed for a complete blood count ("CBC") (CPT-4 code 85023 or 85027) from 1993 through 1996. (Compl. at 11). These additional indices were automatically generated whenever the automated blood analyzer used by defendant processed a CBC. (Compl. at 11). Defendant billed for the CBC and then separately billed for the additional indices, which, according to plaintiff, violates the Medicare Act because they are rarely medically necessary, and they should be specifically ordered by a physician. As a result of defendant's billing procedure, Medicare paid an additional $225,000 for the over 88,000 claims submitted to it between July 1, 1993 through December 31, 1996.

Plaintiff also asserts that Medicare requires that specific blood chemistry tests be bundled together and billed as a single blood chemistry profile if the tests are for the same person, on the same day, and from the same blood sample. The CPT-4 codes generally associate chemistry profiles with the number of individual tests performed. The codes correspond to the number of individual tests to be run because it is more economical for plaintiff to reimburse defendant for the cost of running a battery of tests rather than each individual test. Instead of bundling its automated blood chemistry profiles, plaintiff contends that defendant broke down larger profiles into smaller, component profiles and billed for them separately. Defendant thereby increased its reimbursement by $86,000 for the profiles submitted between July 1, 1993 through June 30, 1994, covering over 9,300 Medicare claims.

Plaintiff seeks to recoup its overpayments on the theory that it paid under mistake of fact and defendant was unjustly enriched. Defendant moves for judgment on the pleadings or in the alternative, for summary judgment, on the following grounds: (1) lack of subject matter jurisdiction, (2) failure to exhaust administrative remedies and issues of ripeness, (3) lack of officially promulgated regulations prohibiting defendant's billing practice, and (4) adequate remedies in law that bar plaintiff's equitable claims.[1] Relying on 42 U.S.C. § 405(h), defendant argues that no subject matter jurisdiction exists. Section 405(h) states that:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h). More specifically, defendant contends that HHS must exhaust its administrative remedies before seeking judicial review.

The parties agree that "Section 405(h) purports to make exclusive the judicial review method set forth in § 405(g)." Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1, 10, 120 S.Ct. 1084, 1091 (2000); Heckler v. Ringer, 466 U.S. 602, 614-5, 104 S.Ct. 2013, 2021 (1984) (stating that the third sentence of Section 405(h) makes

[1] Although the papers were filed before discovery had begun, the parties have had ample opportunity to present pertinent material. Therefore, the Court will treat defendant's motion as a motion for summary judgment.

Section 405(g) the "sole avenue for judicial review."). As are all the cases cited by defendant, Section 405(g) is inapposite.[2]

Section 405(g) states that "any individual" may bring suit in district court after a final decision by the Secretary and requires that "[a]s part of the [Secretary's] answer the [Secretary] shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based." 42 U.S.C. § 405(g). Section 405(g) clearly contemplates administrative exhaustion in cases *against* the Secretary--not cases *by* the Secretary. This reading is further supported by United States v. Aquavella, 615 F.2d 12 (2d Cir. 1980), where the government sought to recover alleged overpayments made to a nursing home under the Medicare Act. The Second Circuit concluded that "§ 405(h) was not intended to preclude the district court from considering the merits of the government's claims of overpayment or [the provider's] defense by way of offset" because "§ 405(h) by its terms applies only to actions brought against the government and not by the government [and] to hold otherwise would totally deprive [the providers] of any judicial review." Id. at 20, 21.

Finally, the policy reasons for requiring administrative exhaustion do not apply when the government is the plaintiff. "Exhaustion is generally required as a matter of preventing premature interference with agency processes, so that the agency may function efficiently and so that it may have an opportunity to correct its own errors, to

---

[2] The cases cited by defendant are distinguishable since none of them involve United States as plaintiff. After the initial papers were filed, defendant brought to the Court's attention one case where the United States was plaintiff, United States v. University of Massachusetts Memorial Medical Center, 2003 WL 22988889 (D. Mass.). I respectfully disagree with the analysis and outcome of the case.

afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review." Weinberger v. Salfi, 422 U.S. 749, 765, 95 S.Ct. 2457, 2467 (1975); Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1, 13, 120 S.Ct. 1084, 1093 (2000) ("insofar as [Section 405(h)] demands the 'channeling' of virtually all legal attacks through the agency, it assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by difference individual courts. . . ."). However, "[o]nce a benefit applicant has presented his or her claim at a sufficiently high level of review to satisfy the Secretary's administrative needs, further exhaustion would not merely be futile for the applicant, but would also be a commitment of administrative resources unsupported by any administrative or judicial interest." Weinberger v. Salfi, 422 U.S. 749, 765, 95 S.Ct. 2457, 2467 (1975). Furthermore, the term "final decision" is undefined by the Social Security Act and the "statutory scheme is thus one in which the Secretary may specify such requirements for exhaustion as he deems serve his own interests in effective and efficient administration." Id. Therefore, it would be inconsistent with the scheme "to bar the Secretary from determining in particular cases that full exhaustion of internal review procedures is not necessary for a decision to be 'final' within the language of § 405(g)." Id. For these reasons, defendant's arguments concerning subject matter jurisdiction, the necessity of administrative exhaustion, and the doctrine of ripeness fail. The Court properly has jurisdiction.[3]

---

[3] This ruling also dictates the conclusion that defendant's fourth contention is unavailing. Defendant argued that equitable claims are barred because the Medicare statutory and regulatory scheme provide adequate remedies.

The parties hotly dispute whether defendant's billing practices were proper and whether plaintiff's claims are enforceable. Apart from the legal questions, there are serious contested issues of fact, and the record here is particularly confusing because the parties refer to outside documents without explaining their meaning, import, and weight of authority. Therefore, on this record, summary judgment is denied.

Accordingly, defendant's motion for summary judgment is denied.

The Court is of the opinion that this Order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from this Order may materially advance the ultimate termination of the litigation.

_____ /s/Rya W. Zobel
DATE RYA W. ZOBEL
UNITED STATES DISTRICT JUDGE